

ABSTRACT  
SOCIAL WORK

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AN EXPLORATORY STUDY OF AFRICAN AMERICAN WOMEN INFECTED  
WITH HIV/AIDS AND RISKY SEXUAL BEHAVIORS

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This study examined the relationship between African American women diagnosed with HIV/AIDS and risky sexual behaviors. The aims of the study were: (1) to describe knowledge related to sexual transmission of HIV/AIDS; (2) to determine high-risk sexual behaviors; and (3) to discuss intervention needed to reduce risky sexual behaviors.

The setting was Positive Impact, a non-profit agency located in Atlanta, Georgia that provides counseling to those diagnosed with HIV/AIDS. The sample consisted of 25 African American women between the ages of 18 to 50. The participants were given a 97-item questionnaire to assess demographics, knowledge about the sexual transmission of HIV/AIDS, and risky sexual behaviors. The data was analyzed using descriptive statistics and the chi-square goodness-of-fit test. The findings indicated that although the participants had a high level of knowledge about the sexual transmission of HIV/AIDS, they still engaged in risky

sexual behaviors. These results are valuable for clinicians because it will aid in educating individuals about risky sexual behaviors. Also, it will be useful for developing intervention programs and implementing policies that may eventually decrease risky sexual behaviors and the spread of HIV/AIDS among African American women.

AN EXPLORATORY STUDY OF AFRICAN AMERICAN WOMEN INFECTED  
WITH HIV/AIDS AND RISKY SEXUAL BEHAVIORS

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## CHAPTER ONE

### INTRODUCTION

This chapter introduces the problem of the AIDS epidemic and gives the reader an overview of the study. There are several areas covered in this section starting with the historical analysis of the virus and how it is transmitted. The following section identifies the statement of the problem which entails various aspects of how AIDS affects the African American community, especially women. The next section discusses the significance of this study and what implications can be made for further use.

The inception of the Acquired Immune Deficiency Syndrome was first identified in the United States in 1981, when doctors in New York City and San Francisco noticed a growing number of deaths among young men who had health problems relating to the immune system (Hombs, 1992). This data convinced society that the disease was safely contained in predominately homosexual populations. In the following decade over 144,000 people, including men, women, and children died due to HIV, the virus that causes AIDS.

The HIV/AIDS virus is no longer a disease that effects Caucasian, gay males. It is a social epidemic affecting society regardless of race, age, gender, or economic status

(Land, 1994). HIV/AIDS virus is only transmitted by the direct exchange of blood, semen, or vaginal secretions. Research to date shows that HIV can be transmitted through sharing toilets, baths, eating, utensils, or other items or places. It cannot be transmitted by living in the same household or working together with someone who is infected. There is no research indicating that it can be transmitted through casual contact such as hugging or kissing (Hombs, 1992).

#### **Statement of the Problem**

African American women are eight times greater at the risk of being infected with HIV/AIDS than any other ethnic group (Land, 1994). According to Land, women of color constitute 72% of those infected, 52% of those women are African American. Land states that AIDS is the leading cause of death among African American women between 15 and 44 (Land, 1994).

According to the Harvard AIDS Institute, by the year 2000 more than half of all the country's AIDS cases will be within the African American community (Crockett, 1997). The Centers for Disease Control and Prevention (CDC) in Atlanta emphasizes the extent to which the African American Community is being affected by the epidemic of AIDS and other sexually transmitted diseases. According to the CDC, the reasons for the growing epidemic have nothing to do with race, ethnicity, or a government conspiracy to eradicate the

Black community. The CDC states that risk is not determined by whether or not they are homosexual, straight, male or female, but continuing to have unprotected sex with multiple partners or people they barely know (Crockett, 1997).

Hombs (1992) reports that poor women, especially women of color, constitute a large number of people living with HIV (Hombs, 1992). They represent a group that is disenfranchised by the economic, healthcare, and social service systems. They are faced with not only coping with their own illness, but also the illness of a spouse or child who may or may not outlive them. Women are more likely to be infected, rather than to transmit HIV through sexual contact. Less than 1 percent of reported cases have resulted in the sexual transmission of the virus from a woman to a man (Hombs, 1992). Similarly, Segel (1993) conducted a study of 379 couples and found a 1 percent rate of female-to-male transmission of HIV, compared with a 20 percent rate of male-to-female transmission (Segel, 1993).

African American women have a history of disfranchisement, marginalization, and poverty. Their HIV/AIDS medical needs have gone unrecognized in health care planning. Without an AIDS diagnosis women are denied medical assistance. Women with HIV do not qualify for health benefits, childcare, rent subsidies, or other support services such as mental health counseling (Land, 1994).

Many women die before having being considered eligible for treatment (Land, 1994). Consequently, when treatment is given, the drugs have an unknown affect on women since they were developed for men. Hence, there is a need for further research treatment to be conducted on women with AIDS (Land, 1994).

According to Barker, African American women have not been well represented as a target for AIDS education. There are limited studies that examine the relationship between knowledge and sexual behaviors. Barker suggests that the increasing rates of HIV/AIDS among African American women may be due to practicing risky sexual behaviors (Barker, 1998). What determines risky sexual behaviors? Risky sexual behaviors can be grouped into three categories:

- (1) exchanging bodily fluids through sexual activities;
- (2) lack of using condoms during those sexual activities;
- (3) choosing sexual partners without thinking about the repercussions (i.e., having sex with multiple partners or with partners who have had multiple partners).

Women with a single partner usually do not perceive themselves at risk because of a monogamous relationship. These women place themselves at high risk of becoming infected due to either lack of condom or spermicide usage (Barker, 1998). African American women who may not perceive their sexual practices as being high risk, may be more prone to becoming infected (Barker, 1998). Based on previous findings, further research

is needed to determine the relationship of the knowledge women have about the sexual transmission of HIV/AIDS and their sexual behaviors.

Despite medical research, there is still no cure for HIV/AIDS. Therefore, the only means to prevent the virus is to try and change high risk behaviors. Abstinence is obviously the most effective way of preventing HIV through sexual transmission. Many adults and adolescents fail to use this strategy (DiClemente and Peterson, 1994). According to DiClemente and Peterson (1994), the expectation that most sexually active adults and adolescents will consider abstinence is unrealistic. For most people that are not celibate, the safest alternative for reducing their risk would be to consistently use a condom. Changing high risk sexual behavior is a difficult task because the decision to use condoms occur in the context of interpersonal relationships and lifestyles. There are many factors that may contribute to the decision of condom usage including age, gender, cultural differences regarding sexuality, and sex-role relationships (DiClemente and Peterson, 1994).

### **Significance of the Study**

The findings in the literature review indicate that there is a relationship between risky sexual behaviors and HIV/AIDS. Over the past decade the challenges involved in lowering the risk of HIV/AIDS among African American have increased (Land, 1994). Land has reported that the risk of

contracting AIDS is more than fifty percent greater for African American women than any other ethnic group (Land, 1994). There has been a forty percent increase in AIDS cases among African American women of childbearing age (Crockett, 1997). The Centers for Disease Control and Prevention reports that AIDS accounts for about one-fifth of deaths among African American women between the ages of 25 to 44. Research suggests that this may be attributed to the relationship between prevention behavior and the perception of risk (Croteau, 1997). These women must learn how to modify behaviors that may put them at high risk. African American women may not consider themselves in stereotypical high risks groups, such as gay white males. Thus, it is imperative to educate African American women on behaviors that may place them at high risk for contracting the disease or being re-infected (Land, 1994). Information and disparities between knowledge and behavior will be useful for clinicians because it can enable them to develop intervention programs by educating women on risky behaviors which may curtail the increase of the virus among African American women.

### **Methodology**

The proposed study examines the relationship between knowledge of HIV/AIDS and risky sexual behavior. The sample consisted of 25 African American women between the ages of 18 to 50 that were diagnosed with HIV/AIDS. Participants

were given a 96-item questionnaire. The items included questions determining sexual behaviors, perceptions about safe sex, AIDS knowledge, disclosure to others about having HIV, sexual compulsitivity, and future sexual behaviors. The findings suggests that the knowledge about sexual transmission of the virus does not necessarily affect sexual behaviors. Even though women were considerably knowledgeable, they still engaged in risky sexual behaviors. Thus, the researcher concludes that further research is needed to examine other factors which may contribute to the reason why women engage in risky sexual behaviors.

### Summary

The purpose of this chapter was to give the reader an overview of the study. The introduction, gives the reader an overview by including the purpose, significance, and the methodology implemented in the study. The second chapter, the literature review, includes selective data about HIV/AIDS that is pertinent to this study, various studies that have been previously conducted, and further research yielding interventions.

The third chapter, the methodology, identifies the methods utilized in the study as the setting, sample, measurement, and statistical tests used. Chapter four, the results, consists of the data analysis. In the fifth chapter, the conclusion, the results of the study are discussed and compared to the data in the literature review.



Also, the research discusses the limitations of the study and suggests research for future practice. Finally, in chapter six, the implications for social work practice are discussed.

## CHAPTER TWO

### REVIEW OF LITERATURE

This chapter begins with a discussion of how AIDS affects women. Next, there is a specific look at AIDS and African American women. Risky sexual behavior is also discussed especially as they pertain to African American women's education and intervention approaches.

#### Women and AIDS

According to Wortley, the AIDS epidemic on women is substantial and warrants an updated analysis (Wortley, 1996). To some extent all sexually active women are biologically at risk of being infected with HIV. Social forces such as poverty, sexism, and other forms of discrimination are major issues (McNair, 1997). Many argue that poverty and inequality are leading risks for the HIV virus. Recently, a study was conducted in Florida to investigate HIV infections through heterosexual transmissions (Farmer, 1996). The population consisted of 1,082 pregnant women receiving prenatal care at a clinic. Research indicates that there was a "statistically significant association between being infected with HIV and having used crack cocaine, having had more than five sexual

partners in a lifetime, or more than two sexual partners per year of sexual activity. Also, the results from this study associates the likelihood of becoming infected with HIV with exchanging sex for money or for drugs or having sexual intercourse with a high risk partner" (Farmer,1996).

### **African American Women and AIDS**

The AIDS epidemic is disproportionately affecting the African American community, especially women (McNair, 1997). Statistical data show that African American women are more at risk of dying due to complications from the virus than men (McNair, 1997). Research suggests that African Americans may be largely infected because of sexual behaviors (Graves, 1991). Until further research is conducted and treatment is more accessible, it is necessary to decrease the number of women being infected with the virus. Their knowledge of the transmission of the virus and sexual behaviors are areas that need to be explored.

African American women represent the fastest growing group to develop HIV/AIDS (Land, 1994). Urban mortality rates indicated that AIDS is the leading cause of death among African American women between the ages of 15 and 44 (Dicks, 1999). It is predicted that in the twenty-first century AIDS will be the leading cause of death among minority women of child bearing age (Land, 1994). Adams (1995) reports that African American women are contracting the AIDS virus three times faster than Caucasian women

(Adams, 1995). Although both groups of women are at risk for heterosexual transmission, African American women pose a greater risk due to having sex with bisexual men. This may be due to in part to, a larger number of gay Black men report having sex with both men and women. Research indicates that 30% of gay Black men are bisexual compared to 13% for gay White men (Adams, 1995).

### **Risky Sexual Behaviors**

The increasing rates of HIV/AIDS is not only due to high risk behaviors and sexually transmitted disease, but also the social and economic factors of discrimination and alienation. Jenkins (1993) observed surveillance data to determine the ratios and rates of HIV/AIDS for blacks and whites. Jenkins (1993) concluded that there is no evidence to suggest that African Americans are more biologically at risk for contracting AIDS than whites. "The differences in disease rates are due to differences in the distribution of risk behaviors, the existence of concurrent conditions (such as genital ulcer diseases), and lack of access to early diagnosis and treatment" (Jenkins, 1993). The findings also suggest that the high rates of the infection of African American women is the result of intravenous (IV) drug use and their partners that also use IV drugs. Women in black communities are at greater risk because of their own risk behaviors, and through the risk behaviors of partners (Jenkins, 1993).

According to Johnson (1993), the major risk factors associated with contracting HIV/AIDS include: the number of sexual partners, specific sex practices with sex partners, history of sexually transmitted diseases, substance use history, history of sexually transmitted diseases, and failure to use condoms. Johnson (1993) conducted a study with 200 African American men and 205 African American women. The participants were college students attending school in southern states. The results of this study revealed that having a lower level of knowledge about AIDS was significantly correlated with HIV/AIDS. The second major area that was examined was the attitudes about the use of condoms. The study found no significant difference in attitudes about condom usage among the participants (Johnson, 1993).

Similar to Johnson's (1993) findings about high risk sexual practices, Barker (1993) asserts that risky sexual behaviors can be measured in terms of using condoms, having multiple sexual partners, or having a partner with a history of injecting drugs. Women that become infected outside of these situations may face other risks that are just as serious, such as the increase of sexually transmitted diseases (STD's) among crack cocaine users in the African American community. This study reveals that the increase of African American men having sex with men as well as with women is also a concern that places women at a high risk.

Men who have anal intercourse with women also place women at a high risk. Thus, African American women are at high risk of contracting HIV/AIDS other than failure in using condoms (Barker, 1993).

### AIDS Education

African American women are under represented in terms of AIDS education. An exploratory intervention known as the Healthy Mamas Project was conducted to determine if HIV/AIDS education made a difference in the participants attitudes about using condoms and the consequences involved. The intervention was geared towards teaching the women to understand and use condoms as a way of lowering their risk. The participants were low-income African American mothers of elementary school children in California. The women participated in six training sessions on the prevention of HIV/AIDS. The women were given AIDS knowledge based questionnaires at the initial training and then given the same questionnaires at the last training session. There was a three-month lapse between the training sessions. Research indicates that 42% of the participants expressed increased trust and resolved to use condoms to reduce the risk of being infected with HIV/AIDS. Therefore, the study concluded found that educational training in regards to AIDS transmission is beneficial in lowering the risk for African American women (Barker, 1998).

Green (1994), conducted a study to examine the relationship between the knowledge about AIDS and reported risky behaviors. The sample consisted of 50 African American female graduate students at a college in the south. Findings suggest that there was a significant difference in the mean knowledge scores between participants who reported having risky behaviors such as treatment for STD, condom usage, and having sexual relations with someone who they thought had AIDS (Green, 1994).

Hubbs-Tait (1995) found a relationship between moral reasoning, AIDS knowledge and risky sexual behavior. They conducted a study on 103 people, 34 males and 69 females with a mean age of 19. All of the participants were Caucasian, undergraduate students from a small mid-western university. The results indicate that moral reasoning was significantly inversely related to two measures of risky behavior such as risk during vaginal and anal intercourse. The authors suggest that future research needs to be conducted on the relationship between moral reasoning and moral behavior (Hubbs-Tait, 1995).

### **Intervention Approaches**

Intervention programs seldom meet the needs of African American women. The findings of a study of risk-reduction messages targeted to African American women in urban areas indicated that African American women were more likely to have empowering behaviors such as getting tested for HIV and

to have a better understanding of high-risk behaviors if the messages stressed culturally relevant values. These values include stressing pride in one's culture, understanding how HIV affects the African American communities in general, and the knowing how it could eventually affect their children (Land, 1994).

A majority of the intervention programs for people with HIV/AIDS have been geared toward homosexual males. According to McNair (1997), there is limited research on safe sex practices among African American women and the reduction of risky sexual behaviors. McNair (1997) suggests that since their male partners' risk increase their risk for contracting HIV, interventions must include relationship dynamics. Efforts in preventing HIV virus in women should focus on the ways they negotiate sexual encounters with male partners, in addition to increasing their awareness about HIV.

Pervasive risk was a concept used to explain the behavior of those who are already at high risk for HIV/AIDS, yet continue to participate in risky behaviors. This concept is useful to explain why individuals that are knowledgeable about HIV/AIDS continue to place themselves at risk despite the consequences. McNair (1997) conducted a study in a sample of 278 African American women in order to explore the nature of risk-taking behaviors related to the HIV virus. It was hypothesized that the increased risk for HIV would be



associated with a variety of risky behaviors across several domains such as demographics and drug use. The results indicated that women engaged in risky behaviors related not only to HIV but also to other health risks, such as cigarette smoking and substance abuse. Condom usage was a factor used to determine the risk for HIV. The results also suggested that the risk for HIV/AIDS could be determined whether one engaged in isolated sexual behaviors but include a variety of risk taking behavior ( McNair, 1997).

Past research suggests that preventive efforts to curtail the spread of AIDS have largely focused on condom usage. In addition to being at risk for AIDS by not using a condom, the risk of spreading a sexually transmitted disease, or an unintended pregnancy are also important. According to Graves (1998), AIDS-risk reduction activities are often identical and linked with contraceptive efforts, especially condom usage. Consequently, it may be useful to look at contraceptive use behaviors in terms of AIDS protection and effective birth control efforts to uncover sexual practices and factors related to behavior as a means of targeting effective AIDS-related preventive measures. Graves (1998) examined the behaviors related to AIDS protection and contraception among African American, Hispanic, and white women. The participants were asked questions about AIDS-related sexual behaviors and attitudes in face-to-face interviews. The findings suggest that a

large proportion of the women from each ethnic group did not use any form of protection during their most recent sexual contact. Also, the results indicate that it may be useful for future research efforts to combine strategies to reduce the spread of AIDS with strategies to reduce unintended pregnancies (Graves, 1998).

Many scholars believe that African Americans' knowledge about AIDS is affected by their distrust of Whites. According to Klonoff (1997) "the effectiveness of health messages in altering attitudes and subsequent behavior is influenced in part by the credibility of the individual who delivers the message." Messages about AIDS delivered by Whites may not be effective for African Americans. Klonoff (1997) conducted a study to determine the relationship among acculturation, distrust of Whites, and AIDS knowledge among African Americans. The sample consisted of 117 adults using the African American Acculturation Scale-Short Form (AAAS-33) and the AIDS Risk Behavior Knowledge Test. The findings indicate that African Americans who had high knowledge about AIDS were more acculturated than those with low knowledge. The findings also suggest that African American knowledge about AIDS may be affected by the distrust of whites, with those who know the least about AIDS being the most distrustful. One recommendation of the study was that education and prevention about AIDS may need to be delivered by African Americans (Klonoff, 1997).

### Critique of Literature

Past research constantly stresses the increase in rise of HIV/AIDS among African Americans, especially women (Land, 1994; Adams, 1995). The literature suggests that the increase is due to the risky sexual behaviors of African American women (Johnson, 1993). There were limited research findings indicating other factors that may be attributed to why African American women have risky sexual behaviors (Adams, 1995; Barker, 1993). Jenkins (1993) suggested that other factors such as social and economic discrimination and the lack of early diagnosis and treatment are of great concern in regards to African American women (Jenkins, 1993). Previous studies suggested that the knowledge these women have about the virus influence their sexual behaviors (Barker, 1998; Green, 1994). Yet, there have been limited intervention programs geared toward educating African American women about the virus and reducing risky sexual behaviors (McNair, 1997). There is no research on women that are already have HIV/AIDS and the issues that affect their risky sexual behaviors. Intervention strategies geared towards helping women that are already infected will decrease their chance of being re-infected and also decrease the spreading of the virus to others.

This study is designed to examine the correlation between AIDS knowledge and sexual behaviors among African American women. Most of the research suggested that there is

a strong correlation between the two variables. Hence, the more knowledge African American women have about the virus the less likely they will be to engage in risky sexual behavior. It is hypothesized that the knowledge African American women have about HIV/AIDS will be inversely correlated with their sexual behavior. The hypotheses for this study are as follows:

HO: Knowledge of AIDS knowledge will have no effect on risky sexual behaviors.

HA: Knowledge of AIDS will reduce risky sexual behaviors.

### **Conceptual Framework**

Prevention of HIV/AIDS requires people to have control over their own behavior and social network. Society has designed strategies to decrease the spread of the HIV/AIDS by educating the public about how the virus is transmitted and how to protect themselves. It is widely assumed that if people are adequately educated about the virus they will likely be more cautious. DiClemente and Peterson (1994) suggests that information alone does not have much influence on health-impairing habits. This study hypothesized that the knowledge African American women have about the sexual transmission of AIDS will not significantly affect their sexual behaviors. This hypothesis is supported by Albert Bandura's self-efficacy theory. Self-efficacy is defined as "the conviction that one can successfully execute the behavior required to produce the outcomes" (DiClemente and

Peterson, 1994). The theory is concerned with an individuals' belief that they are in control over their behavior, motivation, thought processes, and emotional states. An individuals' belief about their capabilities has an affect on what they choose to do in situations. According to the self-efficacy theory, when an individual lacks in self-efficacy they do not effectively handle situations even though they know what to do and have the skills to do it. Thus, the findings in study clearly support Banduras' self-efficacy theory because even though the participants were knowledgable about transmission of AIDS they continued to practice risky sexual behaviors.

### Summary

This chapter primarily focused on the literature and its limitations. The literature indicates that HIV/AIDS is rising among African American women due to risky sexual behavior. Many researchers have suggested that the knowledge women have about the virus is associated to their sexual behaviors. The literature proposed that there are other factors associated with sexual behaviors such as demographics. Past research studies have failed to include African American women that are already infected with the virus. Thus, by including women who are already infected with the virus it will decrease their chances in being re-infected and decrease spreading the virus to others. In the

following chapter the methods used to implement this study are discussed.

## **CHAPTER THREE**

### **METHODOLOGY**

This chapter provides the reader with the methodology utilized in this study. There are several sections discussing the setting, sample and measures used. There are also sections elaborating on the design, procedures, and the analysis. Lastly, the limitations of the methodology are discussed.

#### **Setting**

The setting of this study was Positive Impact in Atlanta, Georgia. Positive Impact is a non-profit agency specializing in mental health care for persons affected by HIV/AIDS. Through a screening and referral process, Positive Impact offers counseling by trained volunteer mental health care providers to individuals with HIV/AIDS who have limited resources.

#### **Sample**

Convenience sampling was used in this study. The population consisted of twenty five (N=25) African American women that had been recently diagnosed with HIV/AIDS virus. Their ages ranged from 18 to 44 years of age. All of the participants had a history of substance abuse at some point

in their lives. All participants also lived in the metro Atlanta area. Ultimately, the participants were chosen based on their availability.

### Measure

The data were collected by giving each participant a 96-item questionnaire. The instrument was designed to analyze current and past sexual behaviors, risky sexual behaviors, perceptions about safe sex, AIDS knowledge, disclosure to others about having HIV, sexual compulsitivity, and future sexual behaviors. The instrument also asked questions about demographic information such as the age, educational level, and employment status. The questionnaire was designed with open-ended questions, true or false, yes or no, and Likert scale questions. This instrument has been used in other studies and has been tested for reliability and validity.

### Design

This study used a post-test only design, X O. The participants were randomly selected based on their availability. This design was utilized to obtain a representative sample based on the significance of the study. The design was beneficial because the findings can be used to represent African American women in the metro Atlanta area that are infected with HIV/AIDS. In other words, because a representative sample was selected, it is possible to generalize the findings to the population from



which the sample was drawn. One limitation in using the post-test only design is the inability to compare these findings with other tests to determine any changes.

### **Procedures**

The period of this survey was from February 1999 to December 1999. An approval letter was taken to the site in November. The participants were given the surveys in a private counseling room on the second floor of the facility. The surveys were administered to clients when they came to the agency for either an initial intake or a scheduled appointment for counseling. Prior to responding to the survey the participants were given an informed consent form stating that their participation in this study was voluntary. Participants were verbally informed by the therapist about the purpose of the survey and how it may be useful in helping them better serve their clients. The participants were informed that the survey should take about 30 minutes to complete.

### **Analysis of Data**

Data were analyzed using several statistical testing methods. The demographic information was measured using descriptive statistics. The Chi-Square test was used to test variables directly related to the hypothesis.

### Summary

This chapter described the basic methods used to conduct this study. The next chapter will present the data collected.

## **CHAPTER FOUR**

### **RESULTS**

This chapter illustrates the results of the data analysis. There are several sections in this chapter. The first section consists of the demographic data results. The next section focuses on determining whether or not the hypothesis was support by the results. The last section discusses research questions that may directly or indirectly relate to the hypothesis.

#### **Demographics**

The sample consisted of 25 participants African American women that were recently diagnosed with HIV/AIDS. All of the women lived in the metro Atlanta area. The other demographic information collected included their age, educational level, and employment status. Nearly 66 percent of the participants ages ranged from 30-40 years old, with a mean age of 35. Forty-eight percent reported having a high school diploma or GED. The majority of the participants reported having a high school diploma or GED. The majority (64%) of the participants reported being unemployed and receiving temporary or permanent disability. This data is illustrated in Table 1.

Table 1

Study Population (N=25)

Variable	Frequency	Percentage
<b>Gender</b>		
Female	25	100
<b>Ethnicity</b>		
African American	25	100
<b>Age</b>		
20-30	3	12
30-40	16	66
40 and over	3	12
<b>Educational Level</b>		
Not a high school graduate	7	28
High school graduate	12	48
Some college	5	20
Technical college	1	4
<b>Employment Status</b>		
Full time	3	12
Part time	1	4
Unemployed disability	5	20
Unemployed/Other	16	64

**Hypothesis**

The hypothesis states that there will be no significant statistical difference between AIDS knowledge and risky

sexual behaviors among African American women. The participants knowledge pie chart shows that 68% of the participants had more knowledge about the sexual transmission of HIV/AIDS, while the remaining 32% reported having less knowledge. The sexual behavior pie chart shows 64% of the participants always engage in risky sexual behaviors, 16% engage in risky sexual behaviors sometimes, and only 4% engage in the behaviors for 3 to five months. The remaining 16% engage in the behavior six months or longer. The following two 2 pie charts illustrate these results.

Figure 1: Knowledge of AIDS

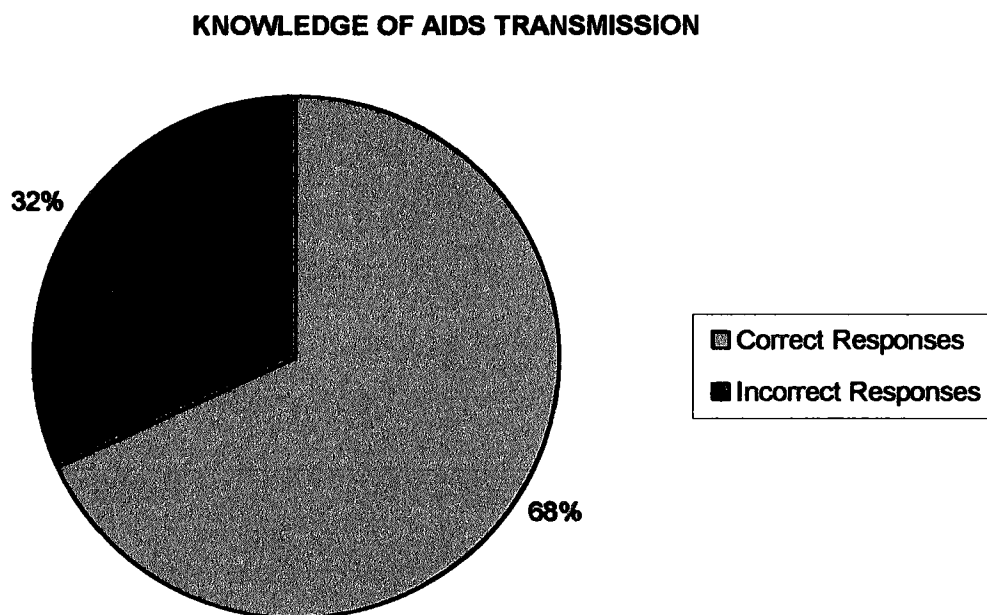
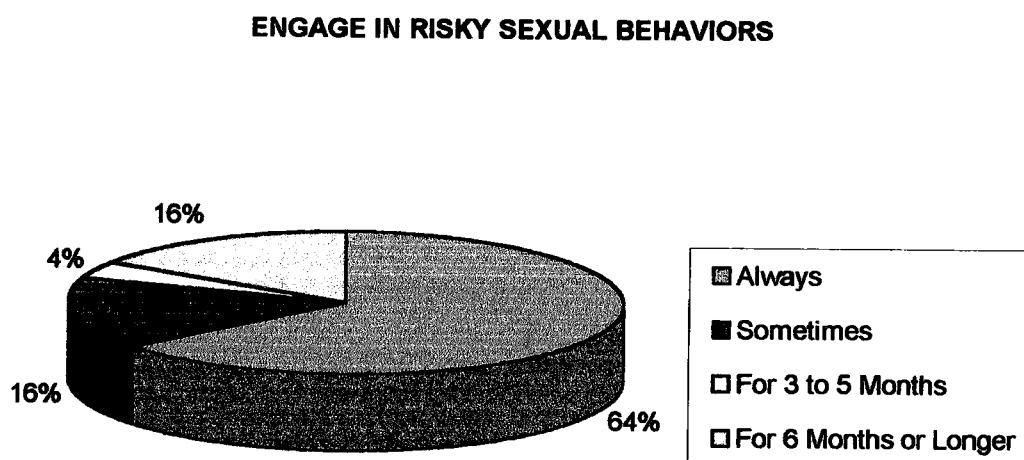


Figure 2: Risky Behavior



### Self-Efficacy

Several questions in the instrument measured the participants' self-efficacy. More specifically, questions 49, 52, and 60 were analyzed. Eighty-three percent of the participants reported that they feel like a responsible person when practicing safer sex. The majority (68%) reported being committed to avoiding risky sexual situations. Seventy-two percent of the participants indicated that they feel proud of themselves when insisting to use condoms.

### Related Research Questions

Although this study aimed to illustrate the relationship between AIDS knowledge and risky sexual behavior there are other variables that are indirectly related to this question. These questions were selected based on the findings from previous literature review.

The following are specific questions from the survey:

- 82. I enjoy having sex with people that I do not know.
- 83. I have lost count of the number of sexual partners that I have been with over the last few years.
- 84. I keep a list of the number of sex partners that I have had.

Table 2

#### Related Research Questions Descriptive Statistics

Variables	N	Minimum	Maximum	Mean	Percent	Std. Deviation
Question 82	25	1	5	1.280	88	.8907
Question 83	25	1	5	2.560	32	1.4166
Question 87	25	1	5	1.960	44	1.0198

Table 2 shows the descriptive statistics of specific questions from the instrument. The responses to these questions were specific questions in the instrument. The questions were based on a likert scale of 1-5, in which 1

represented definitely does not apply, and 5 represented always applies to me. Question 82 shows 88% of the participants definitely do not enjoy having sex with people that they do not know. The mean for question 1 is 1.28 and the standard deviation is .8907. Question 83 shows 32% of the participants have somewhat lost count of the number of sexual partners. Then mean for question 83 is 2.56. and the standard deviation is 1.42. Question 87 shows 44% of the participants did not keep a list of their sexual partners. The mean for question 87 is 1.96 and the standard deviation is 1.02. These statistics suggest that there is some variation in the in the standard deviations which means further research is needed.

### Summary

It was hypothesized that there would be no significant statistically difference between AIDS knowledge and risky sexual behaviors among African American women. The data showed that 68% of the participants had more knowledge about the sexual transmission of HIV/AIDS. Sixty-four percent of the participants always engaged in risky sexual behaviors. Additional findings show that most of the participants did not keep track of the number of all sex partners. These findings and previous research will be discussed further in Chapter 5.



## CHAPTER FIVE

### CONCLUSIONS

This chapter discusses conclusions based on the major hypothesis, the related research questions, and the literature. Conclusions are also drawn from the data analysis results in the previous chapter. Lastly, the demographics are discussed as explanatory variables.

It was hypothesized that there would not be a significant difference in the AIDS related knowledge and risky sexual behaviors of African American women. The findings show that the participants were knowledgeable about the transmission of HIV/AIDS, and yet still engaged in risky sexual behaviors. Albert Bandura's self-efficacy theory supports the hypothesis and suggest that there are other factors contributing to their behavior. The self-efficacy theory suggests that in order to achieve self-directed behavior people need to be given reasons to change risky behaviors, and also the behavioral means, resources, and social supports to do so (DiClemente and Peterson, 1994). People must be willing to change their behaviors, in addition to having skills in self-motivation and self-guidance. These skills must be utilized consistently and at difficult times. The participants in this study show a lack

of having these skills because they continue to practice risky sexual behaviors. Further research is needed to determine the relationship between the participants' self-motivation skills and self-guidance skills and how it affects their behavior. The findings for this study show that nearly 68% of the participants had correct responses when asked about their knowledge of the sexual transmission of AIDS, however 64% of those participants report engaging in risky sexual behaviors. These findings suggest that although African American women had knowledge about how the virus is sexually transmitted they still chose to engage in risky sexual behaviors. Findings also suggest that other factors contribute to risky sexual behaviors. Behavior modification strategies in addition to the affects of substance abuse, the number of sexual partners, condom usage, social and economic problems place African American women at a greater risk of contracting the virus.

Johnson (1993) conducted a study with a sample of 200 African American men and 205 African American women to examine the relationship between AIDS knowledge and sexual behavior and their attitude towards using condoms. The participants were college students attending college in the southern states. Johnson's (1993) findings showed that AIDS knowledge was unrelated to sexual behavior, and having a lower level of knowledge was significantly related to having HIV/AIDS. There was no significant difference in the

attitudes of participants that were infected, compared to those that were uninfected, about using condoms. This study suggests that knowledge has no bearing on sexual behavior whether the individual is infected or not. These findings support the hypothesis that AIDS knowledge does not significantly affect sexual behavior. Similar to the Johnson (1993) study, Green (1994) researched 50 African American females to examine the relationship between AIDS knowledge and reported risky behaviors. The findings suggest that there was a significant difference in the knowledge and risky behavior scores. Green's (1994) result does not support the major hypothesis for this study. There was another study that did not support the major hypothesis. Barker (1998) implemented an exploratory intervention program known as the Healthy Mamas Project to determine if HIV/AIDS education made a difference their attitudes about using condoms. The intervention was based on a six week training session geared towards teaching the women to understand the importance of using condoms and how to use them in an effort to lower their risk. The participants took a pre-test during the initial session and a post-test at the last session. Nearly 42% of the participants reported having increased knowledge and resolved to using condoms more (Barker, 1998). This study proved that educational training is beneficial in lowering the risk of African American women contracting the virus. Due to the findings in this study,

other factors contributing to the risky sexual behaviors of African American women must be considered. The increase in HIV/AIDS is not only due to high risk behaviors and sexually transmitted diseases, but also to social and economic factors (Jenkins, 1993).

Jenkins (1993) conducted a study to examine the rates and ratios of HIV/AIDS among African Americans and Caucasians. The findings illustrated there is no evidence suggesting that African Americans are biologically more at risk for contracting the virus than Caucasians. His findings also suggest that African American women are disproportionately infected due to their IV drug use and their partners that use IV drugs (Jenkins, 1993). According to Jenkins (1993), "the differences in disease rates are due to differences in the distribution of risk behaviors, the existence of a sexually transmitted disease, and the lack of receiving an early diagnosis and treatment." Hence, more research is needed on the social factors attributing to increase of HIV/AIDS among African American women.

Based on the findings in this study and other literature, the findings suggest that other factors, such as the number of sexual partners, are related to risky sexual behavior. Station (1999) conducted a study on young adults between the ages of 19 and 21 and found having sex with multiple partners increased their chance of chance of being infected with the virus. Having multiple sex partners is

just as risky as not practicing safe sex or using IV drugs. Johnson (1993) also suggests that the number of sexual partners is a major risk factor. Crockett (1997) reports that the reason HIV/AIDS is spreading among African American women is due to them continuing to have sex with multiple partners or people they barely know. Due to these astonishing reports, the researcher decided to examine the relationship between compulsive sexual behaviors such as multiple sex partners and HIV/AIDS among African American Women. Three questions were analyzed to determine if multiple sex partners affected the chances of women becoming infected: 1) I enjoy having sex with people that I do not know; 2) I have lost count of the number of sexual partners that I have been with over the last few years; 3) I keep a list of the number of sex partners that I have had. The majority (88%) of the participants reported that they never enjoy having sex with people that they do not know. Thirty-two percent report having lost count of the number of sexual partners they had over the past few years. Then, 44% reported that they never keep a list of sex partners that they had. The results from this study indicate that the participants had a significant number multiple partners, nearly 44% of the did not know how many. Thus, these participants were merely relying on their memory.

Findings show that the participants were knowledgeable about the transmission of HIV/AIDS, yet still engaged in

risky sexual behaviors. This suggests that there are other factors contributing to their behavior. The self-efficacy theory suggests that in order to achieve self-directed behavior people need to be given reasons to change risky behaviors, and also the behavioral means, resources, and social supports to do so (DiClemente and Peterson, 1994). People must be willing to change their behaviors, in addition to having skills in self-motivation and self-guidance. These skills must be utilized consistently and at difficult times. The participants in this study show a lack of having these skills because they continue to practice risky sexual behaviors. Further research is needed to determine the relationship between the participants' self-motivation skills and self-guidance skills and how it affect their behavior.

Based on the findings most of the participants had a low level of self-efficacy. The participants knew what to do in order to avoid risky sexual behaviors, but still chose to take risks. Participants high level of AIDS knowledge clearly depicted their capabilities. Thus, according to the self-efficacy theory the participants' lack of self-efficacy affected their ability to engage in risky sexual behaviors.

#### **Limitations of the Study**

There were several limitations in this study. The first limitation was the convenience sampling method. The participants were chosen either when they came in for an

initial intake or for a therapy session. The second limitation was the post-test only design. Since the data were collected once it could not be used for comparison to detect any changes in the participants' sexual behaviors. The third limitation was the lack of literature on African Americans that are already infected with HIV/AIDS. None of the studies used a sample of African American women who were already infected as part of their research.

### **Summary**

This chapter gave the reader an overview of study. The findings were discussed in detail and compared to the literature review. Various studies that either supported or rejected the hypothesis were also mentioned. The limitations of the study were also discussed. Finally, the researcher mentioned that future research is needed on African American women that are already infected with HIV/AIDS.

## CHAPTER SIX

### IMPLICATIONS FOR SOCIAL WORK PRACTICE

In this chapter the researcher discusses the implications for social work practice based on this study. There is discussion regarding the implications for future research, direct practice, program policy, and government policy.

The findings in this study and previous studies reveal that there is limited research on women that are already infected with HIV/AIDS. Women with AIDS have recently accused scientists of failing to conduct research that could help and prevent the disease from affecting other women. Since women have raised this concern scientists have started to change the direction of research to include issues that solely affect women. Findings reported by the Centers for Disease Control and Prevention (CDC) show that the number of women with AIDS has doubled in the last 10 years. Due to the controversy of not including women in the AIDS research, scientists are slowly trying to change the definition of AIDS. They are trying to alter the definition by including female-related symptoms. Researchers are hoping to study how the disease develops in women and how it affects their reproductive system (Wheeler, 1995).



The World Health Organization (WHO) predicts that by the year 2000, 90% of the AIDS cases will have been transmitted through heterosexual sexual activity. It is predicted that more women than men will be infected. Although substantial research is lacking in this area, it has also been predicted that having sexual intercourse during menstruation increases the risk of women becoming infected. Some studies have shown that women may also increase their risk by having sex with non-circumcised men depending on his sexual history (Sherr, 1993).

When comparing the populations of other studies, none of the studies conducted research on African American women who were already infected with HIV/AIDS and risky sexual behaviors. However, all of the participants in this study were infected with HIV/AIDS. In order to help reduce the increase of HIV/AIDS it is important to identify risky behaviors of those who are already infected. Strategies geared towards reducing risky behaviors will eventually decrease the rise of women being re-infected with HIV. This will ultimately decrease the number of women having full blown AIDS and/or spreading the virus to other individuals. This study can be very useful because it reveals that African American women who are already infected with the virus are very knowledgeable about the sexual transmission, yet still engage in risky behaviors. Thus, further research

is needed to examine why African American women that are already infected still practice risky sexual behaviors.

The findings in this study are useful for clinicians in direct practice because it will enable them to better serve their consumers. This data can provide clinicians with the understanding in helping a population of women that have already been infected with the virus. Mancoske (1996) reports that since there are suicide risks among people living with AIDS, clinicians must be well prepared when dealing with this population.

Past literature indicates that women, especially African American women are being overlooked in regards to intervention strategies implemented to curtail the spread of HIV/AIDS. Without programs geared towards helping women that are already infected, the virus may spread more rapidly. Thus, helping these women may decrease their chances of becoming re-infected and/or spreading the virus to others. The findings in this study demonstrate the urgent need of implementing programs especially geared towards helping African American women that are already infected.

Also, based on the findings in this study, policy makers should understand the urgent need of getting bills passed that will help African American women living with AIDS. Thus, women are usually overlooked when it comes to getting proper medical treatment. The results from this study should alert policy makers that African American

women are also in specialized programs that may decrease their risky sexual behaviors. By taking this approach policy makers could save the lives of women that are already infected and others as well.

### Summary

This chapter provided the reader with social work practice implications based on the findings in this study. The study discussed future research implications since there is limited research among African American women that are infected with HIV/AIDS. The chapter also discussed how the findings in this study can be useful in helping clinicians better serve their clients. Finally, the findings can also aid programs to improve and/or develop more programs especially geared towards the needs of African American women. Based on these findings policy makers can introduce new bills that will enable African American women that are already infected with the virus in obtaining better medical treatment which may lower their mortality rates.

APPENDIX A  
CONSENT FORM

I agree to participate in the research entitled, The knowledge about risky sexual behaviors of African American women infected with HIV/AIDS, which is being conducted by Carisa A. Sellers, School of Social Work, Clark Atlanta University. I understand that my participation is entirely voluntary. I am allowed to refrain my consent at any time without penalty and have the results of the participation, to the extent that it can be identified as mine, returned to me, removed from research records or destroyed.

The researcher have explained the following:

1. I will be given a questionnaire and have 30 minutes to complete.
2. The results of my participation will be anonymous.
3. The researcher does not expect risks or discomforts.
4. This study seeks to indicate how the knowledge
5. The experimenter will answer any further questions about the research.

---

Signature of Experimenter

---

Signature of Participant

APPENDIX B  
SITE APPROVAL LETTER

I, \_\_\_\_\_, give Carisa A. Sellers permission to conduct research at our facility for the sole purpose of completing the degree requirements of Master of Social Work at Clark Atlanta University. The experimenter has explained that the pre-existing data collected in this research will not be used for other purposes. The agency and/or participants will not be at risk or experience discomforts. The agency has voluntarily let the experimenter use their data and may exempt it at any point to the extent that it can be identified.

---

Researcher

---

Site Liaison

## APPENDIX C

## SURVEY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

office use only below this line

Confidential Client Code: \_\_\_\_\_

Gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Age: \_\_\_\_\_

## APPENDIX C

(continued)

1. Are you HIV positive?
  - 1)\_\_\_ Yes
  - 2)\_\_\_ No (skip to question #6)
  - 3)\_\_\_ Unsure (skip to question #6)
2. When did you first test positive for HIV? (If you are unsure of the specific year please give your best estimate)  
Year\_\_\_
3. Did you suspect that you were HIV positive before you tested positive?
  - 1)\_\_\_ Yes
  - 2)\_\_\_ No
4. Are you currently receiving medical care for HIV?
  - 1)\_\_\_ Yes
  - 2)\_\_\_ No
5. Where do you most often get medical care for HIV?
  - 1)\_\_\_ Private doctor/physician
  - 2)\_\_\_ Health Maintenance Organization (HMO)
  - 3)\_\_\_ Public health clinic, county health department, public hospital (Grady, etc)
  - 4)\_\_\_ VA hospital or clinic
  - 5)\_\_\_ Other \_\_\_\_\_
  - 6)\_\_\_ I am not currently getting medical care for my HIV infection

## APPENDIX C

(continued)

5. Have you ever been diagnosed with AIDS?

1)\_\_\_ Yes

2)\_\_\_ No

6. Which best describes your education?

1)\_\_\_ Did you not complete high school

2)\_\_\_ High school graduate or GED

3)\_\_\_ Some college

4)\_\_\_ Technical college graduate

5)\_\_\_ Associates degree

6)\_\_\_ Bachelors degree

7)\_\_\_ Graduate degree or professional degree

7. Are you currently working?

1)\_\_\_ employed full time---40 hours per week

2)\_\_\_ employed part time ----less than 40 hour per week

3)\_\_\_ Unemployed----on a permanent or temporary disability

4)\_\_\_ Unemployed---- other

---

Sexual Behavior

Now we would like to ask you a few questions about your sexual behavior.  
Remember that your responses on all of these questions are completely confidential.

---



## APPENDIX C

(continued)

8. Are you currently in a relationship with someone?
- 1) \_\_\_ Yes
- 2) \_\_\_ No
9. If Yes, How long have you been in this relationship?
- 1) \_\_\_ less than 3 months
- 2) \_\_\_ between 3 and six months
- 3) \_\_\_ between 6 months and one year
- 4) \_\_\_ over one year
10. In the past 60 days have you had oral, anal, or vaginal sex with a man?
- 1) \_\_\_ Yes
- 2) \_\_\_ No
11. If Yes, How many times: \_\_\_
12. In the past 60 days have you had oral, anal, vaginal sex with a woman?
- 1) \_\_\_ Yes
- 2) \_\_\_ No
13. If Yes, How many times: \_\_\_
14. I consider myself to be:
- 1) \_\_\_ Gay, queer, homosexual
- 2) \_\_\_ Straight, heterosexual
- 3) \_\_\_ Bisexual
- 4) \_\_\_ None of the above, unsure

## APPENDIX C

(continued)

In the past 60 days, have you met sexual partners at any of the following:

15. A bar ☐yes ☐no
16. An adult bookstore, sex club, or bathhouse ☐yes ☐no
17. A cruising area (park, mall, restroom, etc.) ☐yes ☐no
18. On the computer ☐yes ☐no
19. At a party ☐yes ☐no
20. Paid for a prostitute or escort ☐yes ☐no
21. At an AA, NA, SLA, OA, CODA, or a CA meeting ☐yes ☐no
22. In the past 60 days, have you had sex with someone in exchange for drugs?
- 1) ☐ Yes
- 2) ☐ No
23. Do you currently use condoms or dental dams when someone gives you oral sex?
- 1) ☐ Never
- 2) ☐ Sometimes but not always
- 3) ☐ Yes I have been always using these for oral sex for about one month
- 4) ☐ Yes I have always used these for oral sex for about 3 to 5 months
- 5) ☐ Yes I have always used these for oral sex for 6 months ago or longer

## APPENDIX C

(continued)

24. Do you plan to start always using condoms or dental dams when someone gives you oral sex?

- 1)\_\_\_ No
- 2)\_\_\_ Yes, within the next six months
- 3)\_\_\_ Yes, within the next 30 days
- 4)\_\_\_ Already always use condoms or dental dams when receiving oral sex

25. Do you currently use condoms when someone inserts his penis into your anus or vagina?

\_\_\_ Does not apply to me because I do not let men insert their penis into my anus or vagina? (Skip the next question)

- 1)\_\_\_ Never
- 2)\_\_\_ Sometimes, but not every time
- 3)\_\_\_ Yes, I have been using condoms every times for about one month
- 4)\_\_\_ Yes, I have been using condoms every time for about 3 to 5 months
- 5)\_\_\_ Yes, I have been using condoms every time for 6 months or longer

## APPENDIX C

(continued)

26. Do you plan to start using condoms every time that someone inserts his penis into you anus or vagina?

\_\_\_ Does not apply to me because I do not let men insert their penis into my anus or vagina? (Skip the next question)

1)\_\_\_ No

2)\_\_\_ Yes, within the next six months

3)\_\_\_ Yes, within the next 30 days

4)\_\_\_ I already use condoms every time I insert my penis into someone's anus or vagina

## FEMALES SKIP THE NEXT THREE QUESTIONS:

27. Do you currently use condoms when you insert your penis into someone's anus or vagina?

1)\_\_\_ Never

2)\_\_\_ Sometimes, but not every time

3)\_\_\_ Yes, I have been using condoms every time for about one month

4)\_\_\_ Yes I have been using condoms every time for about 3 to 5 months

5)\_\_\_ Yes I have been using condoms every time for 6 months or longer

## APPENDIX C

(continued)

28. Do you plan to start always using condoms when you insert your penis into someone's anus or vagina?

- 1)\_\_\_No
- 2)\_\_\_Yes, within the next six months
- 3)\_\_\_Yes, within the next 30 days
- 4)\_\_\_I already use condoms every time I insert my penis into someone's anus or vagina

29. Does not apply to me because I have not inserted my penis into someone's anus or vagina within the past 60 days (skip the next question)

- 1)\_\_\_I never used condoms when I did this within the past 60 days
- 2)\_\_\_I rarely used condoms when I did this within the past 60 days
- 3)\_\_\_I used condoms about every time that I did this within the past 60 days

## EVERYONE CONTINUE

30. When someone inserted their penis into my anus or vagina

\_\_\_Does not apply to me because nobody has inserted their penis into my anus or vagina within the last 60 days (skip the next question)

- 1)\_\_\_I never used condoms when I did this within the past 60 days
- 2)\_\_\_I rarely used condoms when I did this within the past 60 days
- 3)\_\_\_I used condoms about every other time that I did this within the past 60 days
- 4)\_\_\_I used condoms every time that I did this within the past 60 days

## APPENDIX C

(continued)

31. When someone gave me oral sex

\_\_\_ Does not apply to me because nobody has given me oral sex within the past sixty days (skip the next question)

- 1)\_\_\_ I never used condoms or dental dams when I did this within the past 60 days
- 2)\_\_\_ I rarely used condoms when I did this within the past 60 days
- 3)\_\_\_ I used condoms about every other time that I did this within the past 60 days
- 4)\_\_\_ I used condoms every time that I did this within the past 60 days

32. When I gave someone oral sex

\_\_\_ Does not apply to me because I have not given anyone oral sex within the past sixty days (skip the next question)

- 1)\_\_\_ I never used condoms or dental dams when I did this within the past 60 days
- 2)\_\_\_ I rarely used condoms when I did this within the past 60 days
- 3)\_\_\_ I used condoms about every other time that I did this within the past 60 days
- 4)\_\_\_ I used condoms every time that I did this within the past 60 days

Mark the answer that best describes how much you agree or disagree with the following statements about practicing safer sex:

	strongly agree	agree	disagree	strongly disagree
33. People who practice safer sex feel better about themselves.	1	2	3	4
34. Practicing safer sex will help me to stay healthy.	1	2	3	4

## APPENDIX C

(continued)

35. Practicing safer sex all the time is very hard to do.	1	2	3	4
36. Asking my partner about safer sex is embarrassing.	1	2	3	4
37. Using condoms and lubes is fun.	1	2	3	4
38. I feel better about myself if I practice safer sex.	1	2	3	4
39. Using condoms for oral sex is not worth the effort.	1	2	3	4
40. Practicing safer sex is a lot of trouble.	1	2	3	4
41. If I practice safer sex it helps my partners to stay healthy.	1	2	3	4
42. Using condoms and lube is messy.	1	2	3	4

Mark how often the following statements describe how you feel about safer sex.

43. I look for information on how to reduce my risk for transmitting HIV to someone else.

1	2	3	4	5
never	seldom	occasionally	frequently	always

44. I notice ads and posters encouraging me to practice safe sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

45. Articles about risks of unsafe sex upset me.

1	2	3	4	5
never	seldom	occasionally	frequently	always

## APPENDIX C

(continued)

46. It makes me upset when people start talking about how I need to practice safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

47. I think the world would be a better place if more people practiced safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

48. I think that people with HIV would be in better health if they practiced safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

49. I feel that being a responsible person includes my practicing safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

50. I feel that it is my responsibility to insist on safer sex when I am going to have sex with someone who does not have HIV.

1	2	3	4	5
never	seldom	occasionally	frequently	always

51. I feel that it is my responsibility to insist on safer sex even when I am going to have sex with someone who also has HIV.

1	2	3	4	5
never	seldom	occasionally	frequently	always

52. I am committed to avoiding risky sexual situations.

1	2	3	4	5
never	seldom	occasionally	frequently	always

53. I make promises to myself that I will practice safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

54. I have someone who listens when I need to talk about my sexual behavior and HIV.

1	2	3	4	5
never	seldom	occasionally	frequently	always



## APPENDIX C

(continued)

55. I feel comfortable talking to my friends about sex and HIV.

1	2	3	4	5
never	seldom	occasionally	frequently	always

56. I notice society changing in ways that make it easier to practice safe sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

57. I think that practicing safer sex is expected by society today.

1	2	3	4	5
never	seldom	occasionally	frequently	always

58. Instead of risky sex, I engage in other safer sex activities.

1	2	3	4	5
never	seldom	occasionally	frequently	always

59. If I don't have condoms then I do something instead of having intercourse.

1	2	3	4	5
never	seldom	occasionally	frequently	always

60. I feel proud of myself when I insist on using condoms.

1	2	3	4	5
never	seldom	occasionally	frequently	always

61. When I don't practice safer sex, it makes me feel guilty.

1	2	3	4	5
never	seldom	occasionally	frequently	always

62. I keep condoms with me to remind me to practice safer sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

63. I take condoms with me if I think I am going to have sex.

1	2	3	4	5
never	seldom	occasionally	frequently	always

## APPENDIX C

(continued)

Please indicate whether you think that the following statements are true or false.  
Please circle your answer.

- |     |   |   |   |
|-----|---|---|---|
| 64. | HIV can be transmitted by insects like mosquitoes and flies.  | T | F |
| 65. | HIV cannot be transmitted by sharing things like forks or dishes.   | T | F |
| 66. | If I have an undetectable viral load, I cannot transmit HIV to another person.  | T | F |
| 67. | HIV cannot be transmitted by having intercourse with someone as long as the inserting partner pulls out before he cums. | T | F |
| 68. | HIV cannot be transmitted from a woman to a man.  | T | F |
| 69. | Vaseline is a safe lubricant to use with condoms.   | T | F |

In the next sixty days, will you tell partners that you have HIV if you do the following:

- |     |   |     |       |    |
|-----|---|-----|-------|----|
| 70. | If someone inserts his penis into my anus or vagina                 | yes | maybe | no |
| 71. | If someone gives me oral sex  | yes | maybe | no |
| 72. | If I give someone else oral sex                                     | yes | maybe | no |
| 73. | If I insert my penis into someones anus or vagina<br>(females skip) | yes | maybe | no |

Please indicate how often you feel the way described by the following statements.  
Indicate your responses by circling the number that corresponds to how often you feel this way.

- |                 |  |               |               |               |  |
|-----------------|--|---------------|---------------|---------------|--|
| 74.             | I don't worry about becoming re-infected with HIV. |               |               |               |  |
| 1               | 2  | 3             | 4             | 5             |  |
| never feel this | rarely   | sometimes     | usually       | always        |  |
| way             | feel this way                                      | feel this way | feel this way | feel this way |  |

## APPENDIX C

(continued)

75. A man or woman who has intercourse with me and does not use a condom is probably HIV positive.

1	2	3	4	5
never feel this way	rarely feel this way	sometimes feel this way	usually feel this way	always feel this way

76. It is my responsibility to tell people that I have HIV before having sex with them.

1	2	3	4	5
never feel this way	rarely feel this way	sometimes feel this way	usually feel this way	always feel this way

77. I worry about infecting my partners with HIV, regardless of whether or not we use condoms.

1	2	3	4	5
never feel this way	rarely feel this way	sometimes feel this way	usually feel this way	always feel this way

78. Telling people that I am HIV positive before having sex is important to me.

1	2	3	4	5
never feel this way	rarely feel this way	sometimes feel this way	usually feel this way	always feel this way

79. It is my sex partner's responsibility to ask me about HIV before having sex with me...if they don't ask, I don't tell.

1	2	3	4	5
never feel this way	rarely feel this way	sometimes feel this way	usually feel this way	always feel this way

How much do the following statements apply to you? Please circle the response that best fits you.

80. I have sex at inappropriate time or in inappropriate places.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

## APPENDIX C

(continued)

81. I have had sex with someone that I didn't want to have sex with.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

82. I enjoy having sex with people that I do not know.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

83. I have lost count of the number of sexual partners that I have been with over the last few years.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

84. I try to hide my sexual activities from co-workers, friends, family, etc.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

85. Sex is a very important part of my life.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

86. I think about sex all the time.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

87. I keep a list of the number of sex partners that I have had.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

## APPENDIX C

(continued)

88. When I meet someone new, I think about whether I would have sex with them or not.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

89. I have wondered whether or not my sex life is out of control.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

90. I spend too much time thinking about or having sex.

1	2	3	4	5
definitely does not apply to me	does not apply to me	somewhat applies to me	usually applies to me	always applies to me

**MALES ONLY ANSWER THESE QUESTIONS** (Females skip to the Females section below).

In the next 60 days, how likely are you to use a condom or require your partner to use a condom in the following situations:

	definitely will	probably will	probably will not	definitely will not
91. If I am going to insert my penis into someone's anus/vagina	3	2	1	0
92. If someone is going to give me oral sex	3	2	1	0
93. If someone else is going to insert his penis into my anus.	3	2	1	0
94. If I am going to give someone oral sex.	3	2	1	0

## APPENDIX C

(continued)

**FEMALES ONLY ANSWER THESE QUESTIONS**

	definitely will	probably will	probably will not	definitely will not
95. If someone is going to insert his penis into my vagina.	3	2	1	0
96. If I am going to give my partner oral sex	3	2	1	0
97. If someone is going to give me oral sex	3	2	1	0

**YOU ARE FINISHED!**

Thank You for your participation in this important project.

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